melissa a. morrow, dds
pediatric dentistry

SPECIALIZED DENTISTRY FOR INFANTS, CHILDREN, ADOLESCENTS AND CHILDREN WITH SPECIAL NEEDS

5695 Babbitt Street
Haslett, Michigan 48840
(517) 339-0040

Update ______ New Patient ______
Appointment ____

PLEASE
Finish enclosed paper work and return by mail **as soon as possible**.
Once we receive it we will be happy to place your child on our cancellation list in hopes to see them sooner.

Health History Form

Your careful and complete answers to the following questions will be very helpful in the evaluation of your child's dental condition.

PATIENT NAME: ____ Male:____ Female: ____ Preferred name: ______________________
(Please print legibly)

Patient DOB: ______________________ Age (years, months)___________ Place of birth: ____

Patient/Parent: Home phone number:________________________________ Patient /Parent: Cell phone number _________________________________

Address: ____City:____________________________________ State_________

Zip:______________ Email:____

Name of person preparing history: ____ Relationship: ______________ Date: ________________

REFERRED BY: ___________________________________ & their phone number: ____________________

MEDICAL HISTORY

Complication prenatally, in birth, or infancy: ____

Family physician or pediatrician? ____

Surgery (past or planned): ____

Hospitalized? (give age, experience – good or bad): ____

____

____

List all childhood diseases, medical, physical, emotional conditions (give age when occurred): ____

____

____

Current medications: ____ Weight: _________________________________

Give details, past or present, where applicable on the following:

Colds: ________________________________	Psychological counseling: _________________	Rheumatic fever: _____________________
Sinus trouble: ___________________________	Special diets: ___________________________	Blood disorders:______________________
Mouth breathing: ________________________	Gagging, nausea: ________________________	Prolonged bleeding: ___________________
Asthma, hay fever: _______________________	A.I.D.S. _______________________________	Slow healing: ________________________
Epilepsy: ______________________________	Tuberculosis: ___________________________	Radiation therapy: ____________________
Diabetics: ______________________________	Kidney, liver: ________________________	Visual/hearing aids: ___________________
Hepatitis: ______________________________	Heart condition or disease: ______________	

ALLERGIC to: Antibiotics: ______________________Other medications: _________________________ Other: __________________________

Does child become worried or upset over visiting the physician:____

Does your child exhibit any characteristic behavior during physical examination or injections and inoculations? ____________________________________

If so, describe briefly: ____

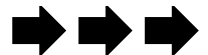
Describe chief oral/dental concern: ____

____

Please sign and date to affirm that the Personal, Medical and Dental (on backside) **information is correct as written and/or updated.**

Parent/Guardian Signature: ____

Date: ______________

Over Please 

DENTAL HISTORY Is this the child's first visit to the dentist? __________ if no, at what age was the first visit: ________________________________

Last visit? __________________ Previous Dentist's name: ______________________________ Location/Phone: __________________________________

Who brushes child's teeth? ________________________ When are child's teeth usually brushed? ____

What brand of toothpaste is used: ____ Is dental floss used? ______________________________

YES	NO	Please give details, where applicable:
______	______	Does child eat between meals?
______	______	Does child eat foods such as candy, cookies, and graham crackers?
______	______	Do child's gums bleed easily?
______	______	Are child's _______ Teeth or _______ Gums sensitive?
______	______	Is your water source a private well?
______	______	Receiving fluoride tablets or drops?
______	______	Have any swellings been noted?
______	______	Were any teeth (primary or permanent) removed by extraction?
______	______	Have there been any injuries to teeth – falls, blows, chips, etc?
______	______	Does child presently, or did he or she ever suck: ____ Thumb ____ Tongue ____ Fingers ____ Other objects? ____________
______	______	Have any measures been taken to reduce the rate of new caries (cavities) such as fluoride rinses, fluoride treatment of special diets?

Note any pertinent feelings, opinions, or past experiences (positive or negative) the patient may have (or have had) with the following:

Dentist: ____

Filling teeth: ____

Anesthetics: ____

X-rays: ____

Fluoride treatment: ____

Cleaning teeth: ____

SOCIAL HISTORY

School: ____________________________________ Grade: ________________ Special or remedial classes? Yes ______ No ______

Best liked subjects: ____

Do you consider your child to be: (describe)

Advanced in the learning process ____

Progessing normally; in the learning process ____

A slow learner ____

Hobbies, sports or pastimes: ____

How many siblings does the child have? _________ Ages: ____

Is child generally considered:

Nervous _______________ Confident ______________ Spoiled ________________ Quiet __________________ Reserved ______________

Calm _____________ Sensitive _______________ Demanding _____________ Loud __________________ Out-going______________

Fearful ____________

Summarize general personality and temperament further here, if you feel that you can add to the above information: ___________________________________

____

____

____

Please use the space below for any comments, questions, or requests which you would like to bring to our attention, or amplify any of the information given above if additional space is required. ____

____

____

Thank you for your cooperation, Dr. Melissa Morrow